3 Durable Medical Equipment Guidelines

3.1 Introduction

3.1.1 General Policy

The Durable Medical Equipment (DME) vendor provides medical equipment, supplies, and services.

The DME provider may also be a qualified Medicaid provider for pharmacy services, but only a DME provider number can be used to bill for items listed in this section.

This section covers all Medicaid services provided by DME providers as deemed appropriate by IDHW. It addresses the following:

- Claims payment
- Prior authorization
- Claims billing
- Durable medical equipment (DME) policy
- Medical supplies policy
- Medical equipment and supplies HCPCS codes
- Oxygen policy
- Prosthetics and orthotics policy
- Waiver Services

***Note*:** Durable Medical Equipment and Supply services are not covered for **CHIP-B** participants.

Refer to the **CHIP-B Appendix section B.1.5** for service limitations for **CHIP-B** participants.

3.1.2 Payment

Medicaid reimburses DME services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance. Medicaid bases pricing on the DMERC pricing for national HCPCS codes.

3.1.3 Healthy Connections

Check eligibility to see if the client is enrolled in Healthy Connections, Idaho Medicaid's managed care program. If a client is enrolled, a referral from the Healthy Connections physician is required before payment will be made.

See **Section 1** for more on Healthy Connections.

3.1.4 Medicare and Medicaid

Providers must enroll with the Idaho Medicaid program separately from Medicare.

If the **client** is dually eligible for Medicare and Medicaid, claims submitted to Medicare through the durable medical equipment regional carrier (DMERC) are electronically crossed over to Medicaid. Consult the DMERC Region D Supplier Manual for procedure codes and billing instructions.

3.1.5 Place of Service Codes

Enter the appropriate numeric code in the place of service box on the CMS-1500 claim form. Not all DME procedure codes are payable at all places of service.

11 — Office

12 — Home (includes residential care facility)

24 — Ambulatory surgical center

33 — Custodial care facility

34 — Hospice

54 — Intermediate care facility/mentally retarded (ICF/MR)

56 — Psychiatric residential treatment center

71 — Public health clinic

72 — Rural health clinic

3.1.6 Program Abuse

Providers are required to follow the rules governing medical assistance.

Medical equipment and supply items used by or provided to an individual other than the client for which the items were ordered is prohibited.

Idaho Medicaid has no obligation to repair or replace any piece of durable medical equipment or supply that has been damaged, defaced, lost, or destroyed as a result of neglect, abuse, or misuse of the item.

Program rules and regulations are strictly enforced and violators are subject to penalties for program fraud and abuse.

3.2 Durable Medical Equipment and Supplies Policy

3.2.1 Overview

Idaho Medicaid will purchase or rent medically necessary durable medical equipment (DME) and supplies for eligible participants residing in community settings. Medicaid will also purchase or rent equipment and supplies provided as a part of a home health agency plan of care.

DME through a Home Health Provider is not a covered benefit for Basic Plan participants.

Durable Medical Equipment is defined as:

- equipment other than prosthetics or orthotics which can withstand repeated use,
- is primarily used to serve a medical purpose,
- is generally not useful to a person in the absence of an illness or injury,
- is appropriate for use in the home, and
- is reasonable and necessary for the treatment of an illness or injury.

While a client is an inpatient of a hospital, nursing facility, or ICF/MR facility, items included in the per diem payment are billed directly to the facility. DME or medical supplies cannot be billed to Medicaid for these participants. Only items that are customized for a specific client, such as prosthetics and orthotics, may be billed separately to Medicaid. Wheelchairs are separately payable for clients in ICF/MR facilities.

Prior authorization for DME must be obtained even if the client has other third party insurance, except if the primary insurance is Medicare.

Additional information about DMERC guidelines is available on the Internet:
www.cignamedicare.com

www.dme.idaho.gov

3.2.2 Billing Procedures

Claims are billed to Medicaid on the CMS-1500 claim form or electronically using the HIPPA compliant 837 professional claim form. Use the appropriate HCPCS procedure codes with each claim. Medicaid uses the same HCPCS codes and modifiers that are used by Medicare. You can refer to the DMERC manual for updated HCPCS codes. Select *DMERC Region D*; select *DMERC Region D Supplier Manual* from the Publications drop-down menu, then select HTML Format.

3.2.3 Documentation Requirements

The vendor is required to obtain all medical necessity documentation **PRIOR** to providing and billing for DME and supplies. Documentation must be kept on file for five (5) years after the date of service. **Documentation must include all of the following:**

- The client's medical diagnosis and description of the current medical condition that requires the equipment or supplies.
- Estimation of the time period (dates) the medical equipment or supply item will be needed and the frequency of use. "As needed" or PRN orders will not be accepted without instructions on how/when the medical equipment or supplies will be used.

- For medical supplies, the description and quantity of the supply needed per month.
- A full description of the medical equipment requested. All modifications or additions to basic equipment must be documented in the attending physician's prescription.
- The original physician's dated signature ordering the equipment and supplies and verifying that all of the above information is accurate and correct is required before billing.
- Medical necessity documentation as required by the *Rules Governing the Medical Assistance Program*. DME rules can be found at IDAPA 16.03.09.106. These rules are available online at: *http://www2.state.id.us/adm/adminrules/rules/idapa16/16index.htm*

3.2.4 Prior Authorization Procedures

To discover which DME products require prior authorization (PA), access the fee schedule on the Medicaid DME Website. If an item requires PA, it is specified in the fee schedule. You may also call EDS at (800) 685-3757 to inquire if a HCPCS code requires prior authorization or for the reimbursement amount for a code.

See **Section 2.3.2** for more information on billing services that require Prior Authorization.

The following rules apply to requests for DME or supplies from DME providers that require prior authorization:

- A prior authorization is a written, faxed, or electronic approval from the Department that permits payment or coverage of a medical item or service that is covered only when authorized by the Department.
- Medicaid payment will be denied for the medical item or service, or portion thereof, which was provided prior to obtaining authorization.
- The provider may not bill the Medicaid participant for equipment and/or supplies not reimbursed by Medicaid solely because the prior authorization was not obtained in a timely manner.
- An exception may be allowed on a case-by-case basis where, despite efforts on the part of the provider to submit a timely request or events beyond the control of the provider prevent it. An explanation of the delay in submission must accompany the request.
- Equipment and/or supplies for an individual will be deemed prior approved if the individual was not eligible for Medicaid at the time these items were approved, but was subsequently found eligible pursuant to IDAPA 16.03.05.051.03; AND the medical item or service provided is approved by the Department by the same guidelines that applies to other prior authorization requests for medical necessity; AND the request was submitted within 30 days of of the date the provider became aware of the individual's Medicaid eligibility.
- A valid prior authorization request is defined as a request from a Medicaid provider of medical equipment and supplies that contains all information and documentation as required by rules to justify the medical necessity, amount and duration for the item(s) or service.
- For items that must be manually priced (there is no set price on file), pricing documentation must be attached to the PA request. Incomplete prior authorization requests will be denied It can be duplicated as needed. If a request has been denied, a new request

FORM AVAILABLE: The DME/Supplies Request Form is included in the Forms Appendix of this handbook.

form and all required documentation can be submitted if there is additional documentation to support the request.

- A copy of the *Idaho Medicaid DME/Supplies Request Form* is available in the Forms Appendix of this handbook. It can be duplicated as needed. If a request has been denied, a new request form and all required documentation can be submitted if there is additional documentation to support the request.
- Refer to **Section 3.2.3** for documentation elements required.
- Medical necessity documentation must show that the participant meets the criteria set forth in the DMERC Supplier Manual (incorporated into Medicaid rule by reference). Select *DMERC Region D*; select *DMERC Region D Supplier Manual* from the Publications drop-down menu, then select HTML Format. Coverage criteria are in Chapters 3 and 4.
- For those items that do not have criteria in the DMERC Supplier Manual, submit documentation from the physician, therapist, etc. that documents the medical necessity of the equipment for the participant. If less costly equipment was considered and ruled out, the documentation should identify the equipment and the reasons it would not meet the minimum medical needs of the participant.
- "Urgent" requests for equipment and supplies required for discharge from the hospital or instances such as supplies for IV antibiotics may be faxed marked "urgent" on the top of the request form. Call the DME Unit at 1-866-205-7403 to notify staff of the incoming request. For urgent equipment and supplies that required dispensing on the weekend or holiday or after business hours, the DME Unit must receive the request the next business day. A screen print of the decision will be faxed to the provider the same business day the request was received.

The DMERC Supplier Manual is available on the Internet:

www.cignamedicare.com

If prior authorization is required, the prior authorization number must be indicated on the claim or the claim will be denied.

3.2.4.1 Where to Send Requests for Prior Authorization

Send or FAX requests for Prior Authorization to:

Idaho Medicaid
Bureau of Care Management
Attn: DME Specialist
P.O. Box 83720
Boise, ID 83720-0036

FAX: (800) 352-6044
Call: (866) 205-7403

If you FAX an "urgent" request, please call and notify the DME Unit.

3.2.5 Purchase, Rental, and Warranty Policy

3.2.5.1 DME Rent/Purchase Decision

All durable medical equipment that requires prior authorization for purchase also requires prior authorization for rental.

Rental payments, including intermittent payments, will be applied toward the purchase price of the equipment. The equipment will be considered **purchased after the tenth (10th) monthly rental payment except those items such as oxygen and ventilators that are continuous rental.** Medicaid follows the payment categories in the DMERC Supplier Manual.

The Department may choose to continue to rent certain equipment without purchasing it. Such items include, but are not limited to apnea monitors and ventilators. The total monthly rental cost shall not exceed one-tenth (1/10) of the total purchase price of the item.

Monthly rental payments **include** supplies, when so designated in the DMERC Supplier Manual, and a full service warranty. Supplies, routine maintenance, repair, and replacement are the responsibility of the DME provider during the warranty period and for continuous rental equipment.

3.2.5.2 Warranty Requirements

Payment will not be made for the cost of materials covered under the manufacturer's warranty. If the warranty period has expired, the provider must have documented on file the date of purchase and warranty period.

Medicaid requires the following minimum warranty periods:

- The power drive of a wheelchair will have a one-year warranty
- An ultra light or high strength lightweight wheelchair will have a lifetime warranty on the frame and crossbraces
- All other wheelchairs will have a one-year warranty
- All electrical components and new or replacement parts will have a six-month warranty
- All other DME not defined above will have a one-year warranty period

If the manufacturer denies the warranty due to user misuse/abuse, this information must be supplied when requesting approval for repair or replacement.

Note:
Items marked with ➲ require prior authorization (PA).

Any supplies **not** listed may require prior authorization.

3.2.6 Covered Equipment

The following items are covered by Medicaid when medically necessary and the least costly means of meeting the client's medical need. Medical equipment for purchase must be new when dispensed. This includes equipment that is issued as a capped rental. This does not apply to short-term rental equipment. Used equipment may only be dispensed and reimbursed when authorized by the Department as used. For items that are covered by Idaho Medicaid, but not by Medicare, refer to the list below for coverage criteria. Check the Idaho Medicaid DME Website (in the fee schedule) or call EDS to verify whether the item/code requires prior authorization.

Items not listed may be submitted for prior authorization and reviewed for medical necessity by the Department. Prior authorization by the Department

may require additional documentation **beyond** what is required in **Section 3.2.3, Documentation Requirements**.

Medicaid covers the following DME items. Items marked with **PA** require prior authorization:

- **PA -** Apnea monitors (with recording feature), if:
    a. there is current documentation of apneic episodes
    b. for renewal, include documentation (download) of the last apneic episode during the last covered period. Apnea monitors are not covered for bradycardia or if the only indication is a sibling with SIDS
- Bath benches/chairs (benches or chairs reported with **E1399 require PA**)
- Bathroom grab bars adjacent to the toilet and bathtub
- Bilirubin lights
    a. for use for hyperbilirubinemia (> 15 days) in an infant/child
    b. use up to 7days does not require prior authorization
- **PA -** Bi-PAP
- Breast pumps (requires prior authorization after the first 60 days), if the following criteria are met:
    a. child and mother are separated more than 24 hours due to surgery or hospitalization
    b. child has dysfunctional sucking due to prematurity, Down's syndrome, cleft lip/palate, or craniofacial anomaly
    c. mother is on short-term medication contraindicating breastfeeding
    d. mother has mastitis

    Note: Authorization should be for the participant who meets the criteria (mother or baby). Can be authorized under the mother when the infant is hospitalized.
- Commode chairs and toilet seat extenders
- **PA -** Communication devices
- **PA -** Continuous Positive Airway Pressure (CPAP) machines
- Crutches and canes
- Electric or hydraulic lift devices designed to transfer a person to and from bed to wheelchair or bathtub; or a lift mechanism for a chair; but **excluding** devices attached to motor vehicles and wall-mounted chairs which lift persons up and down stairs
- **PA -** Equipment for the treatment or prevention of decubitus ulcers, such as overlays or special mattresses. Check to see if the Group One device requires prior authorization. Group Two devices **require** PA. A Group One device must be tried and failed before requesting PA of a Group Two device.
- Equipment used for home dialysis including necessary water treatment equipment
- Glucose testing devices
- **PA -** Glucose monitor, voice synthesized or alternate site monitor
- Hand-held showers

Note:
Items marked with ➔ require prior authorization (PA).

Any supplies **not** listed may require prior authorization.

Call EDS at (800) 685-3757 to verify if a code requires prior authorization.

- Home traction equipment
- Hospital bed (manual), mattresses, trapeze bars, and side rails
- **PA -** Hospital bed, semi-electric. Semi-electric hospital beds may be rented or purchased when **all** of the following circumstances are met:
    a. The physician identifies the participant as unable to operate a manual hospital bed; **and**
    b. The participant resides in an independent living situation where there is no one to provide assistance with a manual bed for the major portion of the day; **and**
    c. The participant is unable to change position as needed without assistance, per DMERC coverage criteria
- **PA -** Insulin Pumps
- Infusion pumps, external ambulatory infusion or implantable
- Intravenous infusion, gastric, or nasogastric feeding pumps
- IPPB machines and nebulizers
- **PA -** Maternity abdominal supports. If the participant has:
    - vulvular variscosities; or
    - perineal edema; or
    - lymphedema; or
    - external prolapse of the uterus or bladder; or
    - hip separation; or
    - pubic symphysis separation; or
    - severe abdominal or back strain
- Medically necessary protective headgear
- Nebulizers
- **PA -** Neuromuscular electric stimulators only when nerve supply to the muscle is intact.
- **PA -** Osteogenesis (bone growth) stimulator
- **PA -** Oximeters. Requires oxygen saturation documentation and physician's order must include continuous or spot check monitoring. Renewal requires oxygen saturations and oxygen liter flow adjustments required during the covered period.
- Oxygen concentrators and tanks/stationary and portable
- Orthotics. **Note:** Check for age limitations on AFOs
- Pacemaker monitors
- Percussors, manual or electric
- **PA -** Power operated vehicles
- **PA -** Prosthetics. **Note:** some require PA; verify HCPCS code with EDS at (800) 685-3757.
- Suction pumps
- **PA -** Transcutaneous electric nerve stimulators (TENS) when proven effective for acute postoperative or chronic intractable pain only when more conservative treatment modalities have failed. **Note:**

Note:
Items marked with ➲ require prior authorization (PA).

Any supplies **not** listed may require prior authorization.

Check the DME Websits or call EDS at (800) 685-3757 to verify if a code requires prior authorization.

documentation is required and the effectiveness must be documented by the physician following a maximum trial period of two months.

- Transfer boards
- **PA -** Ventilators. Diagnoses and conditions requiring ventilator assistance are: COPD, polio, amyotrophic lateral sclerosis, myasthenia gravis, muscular dystrophy, emphysema, bronchitis, musculoskeletal disorders, phrenic nerve damage, spinal cord injuries, multiple sclerosis, congenital trauma, or osteogenesis imperfecta.

  A ventilator is authorized only when a CPAP or Bi-PAP has been proven ineffective or is not appropriate for the medical condition of the patient.
- Walkers **Note:** walkers with hand brakes require prior authorization.
- Wheelchairs are limited to one wheelchair per client no more often than once every five years when Medicare DMERC criteria are met and the requested wheelchair is the least costly to meet the client's minimum medical necessity needs.

  Note: Requests for purchase of a wheelchair require a written physical therapy or an occupational therapy evaluation that documents the appropriateness and cost-effectiveness of the wheelchair and accessories and its ability to meet the client's long-term medical needs. Requests for wheelchair rentals under three (3) months do not require a physical therapist or an occupational therapist evaluation if the need is self-limiting (e.g. fractured femur). Additional months **may** require a physical therapist or occupational therapist evaluation.

3.2.6.1 Wheelchair Repairs

The Department or its designee may prior authorize wheelchair repairs or parts replacements including, but not limited to, tires, footplates, seating systems, drive belts, and joysticks. Repairs or replacement of any of the above items will not be authorized more than once every 12 months.

Specially designed seating systems for wheelchairs may be replaced no more often than once every five years. Seating systems for clients in growth stages must provide for system enlargement without complete system replacement.

3.2.7 Covered Supplies

No more than a one (1) month supply of necessary medical supplies can be dispensed per calendar month. The physician's order must indicate the type and quantity or frequency of use. The participant must request a refill of supplies before they are dispensed.

Note: Quantities in excess of those in the DMERC Supplier Manual require prior authorization

Medicaid covers the following supplies:

- Catheter supplies including catheters, drainage tubes, collection bags and other incidental supplies
- Cervical collars
- C-Pap and Bi-Pap supplies
- Colostomy and urostomy supplies

- Disposable drug delivery system
- Disposable supplies required to operate approved medical equipment such as suction catheters, syringes, saline solution, etc.
- Disposable underpads (limit of 150 per month)
- Dressings and bandages to treat wounds, burns or provide support to a body part
- Fluids for irrigation
- Gloves. (for patient care only). If diagnosis is not ESRD, Medicare does not have to be billed first
- Incontinence supplies for persons over four years of age including, disposable diapers/briefs/pull-ups, etc. Limit 240 per month. Disposable wipes are not covered.
- Injectable supplies including normal saline and Heparin but excluding all other prescription drug items
- Blood or urine glucose monitoring materials (tablets, tapes, strips, etc.)
- Oxygen (gas or liquid) for client-owned systems
- Peak flow meter
- Spacer for metered dose inhaler
- Surgical support stockings. Limit of four (4) stockings every three (3) months if required for both legs. Limit of two (2) stockings every three (3) months if needed for one leg.

3.2.7.1 Oral, Enteral, or Parenteral Nutritional Products, Equipment, and Supplies

Oral, enteral, or parenteral nutritional products do not require prior authorization. However, the vendor must keep the following documentation on file for five (5) years after the date of service:

- Physician's order and documentation of medical necessity
- A nutritional plan, which must include appropriate nutritional history, the client's current height, weight, age, and medical diagnosis. For clients under age 21, a growth chart including weight or height percentile must be included.

The plan must include goals for either weight maintenance or gain. If the medical necessity is a nutritional supplement, the plan must outline the steps to decrease the client's dependence on the continued use of nutritional supplements.

The schedule for reviewing and updating the nutritional plan will be determined by individual needs, but at least annually, and must be approved by the physician.

Nutritional products will be paid in accordance with DMERC guidelines: 100 calories equals one (1) unit. (See Enteral Product Classification list at **www.palmettogba.com**. Under "other partners" select SADMERC, "product classification lists", "product classification lists" (again), enteral nutrition.) For clients taking nutritional products orally, state this in the narrative field on the

Product classification for certain DME can be found at the SADMERC Website: **www.palmettogba.com**

claim. Medicare does not have to be billed first if the product is administered orally.

On the claim, include the number of calories per day ordered by the physician, and number of calories per can in the comments (field #19). Attach a copy of the invoice dated just prior to the date of service.

In the narrative field on the claim, indicate whether or not the client is taking nutritional products orally. Medicare does not have to be billed first if the product is administered orally.

Thickener is covered when medically necessary for use with oral nutrition.

Traditional infant formulas are not covered.

3.2.8 Non-covered Equipment and Supplies

The following are **not** covered under the DME program:

- Services, procedures, treatment, devices, drugs, or application of associated services that the Department or its designee considers investigative or experimental on the date the services are provided.
- More costly services or equipment when less costly, equally effective services or equipment is available, as determined by the Department or its designee.
- Any service specifically excluded by statute.
- Non-medical equipment and supplies and related services.
- Items for comfort, convenience or cosmetic purposes, e.g., wipes, peri-wash, exercise or recreational equipment, etc.

3.2.9 Procedure Codes

All claims must use the appropriate HCPCS codes when submitting a claim for payment.

3.2.10 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Equipment

The following durable medical equipment and supplies **may** be covered for a child through the month of his/her twenty-first (21st) birthday under EPSDT when medically necessary and the least costly means of meeting the medical need:

- Certain therapy equipment such as therapy mats, therapy balls
- Wheelchair tie down restraints
- Personal and comfort items:
  - Toothettes for children who require oral stimulation or have severe spasticity or a deformity in the mother which prevents proper cleaning using a regular toothbrush, waterpiks, or periodontal devices
  - Eating/feeding utensils, such as rocker knives, special plates with rims
  - Page turners
  - Reachers

Prone Stander – The following needs must be identified by a physical therapist and ordered by a physician (limited to no more often than once every five (5) years):

a. Stretching of heel cords
b. Prevention of hip dislocation
c. Improvement of bone density
d. Weight bearing to enhance muscle development
e. Transition to standing/help with transfers

Gait Trainer - The following needs must be identified by a physical therapist and ordered by a physician (limited to one every five (5) years):

a. Promote gross motor development
b. Promote independent mobility
c. Initiate stepping

Specialized Bath Chair - The following needs must be identified by a physical therapist and ordered by a physician (limited to one (1) every three (3) years):

a. Difficulty in bathing due to size
b. Decreased tone/insufficient trunk control
c. Inability to sit independently
d. Need for head and trunk support during bathing

Specialized Toilet Seat – (Limited to children over four (4) years of age.) The following needs must be identified by a physical therapist and ordered by a physician (limited to one (1) every three (3) years):

a. Inability to sit without support
b. Decreased tone/insufficient trunk control

Specialized Car Seat – (Limited to children over four (4) years of age.) The following needs must be identified by a physical therapist and ordered by a physician (limited to one (1) every five (5) years):

a. Proper positioning which cannot be met by a regular car seat
b. Insufficient trunk control/trunk support
c. Decreased muscle weakness/tone; and alternative is to take the child in the vehicle lying down or sitting without needed support
d. Requires support of the head during transport

3.2.11 Oxygen Services

3.2.11.1 Overview

Medicaid will provide payment for oxygen and oxygen-related equipment based upon Medicaid's fee schedule. Such services are considered reasonable and necessary for clients with significant hypoxemia and certain related conditions. Refer to DMERC coverage. Exceptions are listed below. Signed physician's orders are required. A Certificate of Medical Necessity will be considered the same as a physician's order. Using the Certificate of Medical Necessity (CMN) will expedite claim processing. When billing electronically using the HIPAA compliant professional claim form, the oxygen information generally required on the CMN must be included on each claim.

Note:

Oxygen "PRN" or "as-needed" are not acceptable prescriptions.

The prescription and laboratory evidence justifying the use of oxygen must be included with the first claim for oxygen therapy for the client. This prescription and laboratory evidence will be kept on file and will remain in effect for one year from the date the test was taken. If the need is for lifetime, no subsequent CMNs are required unless the order (e.g., flow rate) changes.

3.2.11.2 Exceptions to DMERC Coverage

Age 0 — 6 Months
Lab studies are not required. Prior authorization is not required but must be a physician-ordered therapy and the initial claim must include Medical Necessity documentation or laboratory evidence.

Age 7 Months — 20 Years
Requires lab studies and Medical Necessity documentation. Prior authorization is not required except for conditions that do not meet lab study parameters.

3.2.11.3 Cluster Headaches

Medicaid may pay for oxygen for clients with a diagnosis of cluster headaches. **Prior approval is required from Medicaid**. Include the prior authorization number on the claim. Lab studies are not required. Prior authorization requests must have physician orders that demonstrate the following medical necessity criteria:

a. Other measures, such as Dehydroergotamine and Sumatriptan (Imitrex), have been tried and found to be unsuccessful.
b. Oxygen therapy must have been proven successful on a trial basis for at least one treatment in the emergency room or in the physician's office before it can be authorized for home use.

If both criteria are met, authorization will be given for a six (6) month period. Documentation of successful use and continued need must be received from the attending physician for subsequent prior authorization.

If more than two (2) months elapse without an incidence of a cluster headache, the oxygen authorization will be discontinued until the headaches start again.

3.2.11.4 Physician Orders

The vendor must keep the following information in its files, in addition to documentation listed in **Section 3.2.3:**

- Flow rate and oxygen concentration
- Specific test results, as indicated under **3.2.10.5, Laboratory Evidence**

3.2.11.5 Ventilator Dependent Clients

Idaho Medicaid will authorize payment of oxygen and oxygen supplies and equipment when the client is ventilator dependent. The client does **not** have to meet the PO_2 level of 55 mm Hg or an arterial oxygen saturation at or below 88 percent. The supplier must document on each claim that the client is ventilator dependent. Enter in the appropriate fields when billing electronically or in field 19 on the paper CMS-1500 claim form.

3.2.11.6 Payment Methodology

Idaho Medicaid pays for medically necessary oxygen with an all-inclusive monthly rate. This rate includes the rental of the delivery system and any necessary accessories such as flow valve, humidifiers, nebulizers for humidification, tubing, masks, contents for compressed gas and liquid systems, and nasal cannula/face masks.

In a limited number of cases, the client owns the stationary or portable oxygen delivery system. Medicaid will pay to maintain such systems and pay a monthly charge for compressed gas and liquid systems. Medicaid will cover the cost of disposable items such as cannulas and tubing. The claim must document that the client owns the system.

All rentals must specify actual, inclusive dates of rental and must be billed monthly.

3.2.11.7 Certificate of Medical Necessity

Use of a *Certificate of Medical Necessity* form for oxygen is not required when billing with a **paper claim form** but can expedite payment. A copy of the form can be found in the Forms Appendix of this handbook.

Claims for oxygen services can be billed **electronically** without attachments. Oxygen information must be included on each claim for which services are billed.

Additional information regarding the required values can be found in the *Idaho PES Handbook* in the 837 Professional – Service 3 section.

3.2.12 Prosthetic/Orthotic Description

Medicaid will purchase or repair medically necessary prosthetic and orthotic devices and related services that artificially replace a missing portion of the body or support a weak or deformed portion of the body within the limitations established by Medicaid. Refer to the Documentation Requirements, **Section 3.2.3** and DMERC coverage criteria.

3.2.12.1 Program Requirements

Medical necessity documentation must be kept on file by the vendor for five (5) years after the date of service.

The following program requirements will be applicable for all prosthetic and orthotic devices or services covered by Medicaid. The Medicaid program follows the criteria established in the DMERC supplier manual:

a. A replacement prosthesis or orthotic device may be covered if justified to be the least costly alternative as opposed to repairing or modifying the current prosthesis or orthotic device.

b. An individual who is certified or registered by the American Board for Certification in Orthotics and Prosthetics shall provide all prosthetic and orthotic devices that require fitting.

c. All equipment that is purchased must be new at the time of purchase. Modification to existing covered prosthetic or orthotic equipment will be covered.

d. Purchased prosthetic limbs shall be guaranteed to fit properly for three months from the date of service. Any modifications, adjustments, or replacements within three months are the

responsibility of the provider that supplied the item at no additional cost to Medicaid or the client.

e. No more than 90 days shall elapse between the time the attending physician orders the equipment and the equipment is delivered to the client.

3.2.12.2 Program Limitations

The following limitations shall apply to all prosthetic and orthotic services and equipment:

a. No replacement will be allowed for prosthetic or orthotic devices within 60 months of the date of purchase except in cases where there is clear documentation that there has been major physical change to the residual limb, and a replacement is ordered by the attending physician.

b. Refitting, repairs or additional parts shall be limited to one per calendar year for all prosthetics and orthotics unless a documented major medical change has occurred to the limb and refitting is ordered by the attending physician.

c. All refitting, repairs or alteration requests must have documented medical justification by the client's attending physician.

d. Prosthetic and orthotic devices provided for cosmetic or convenience purposes are **not** covered by Medicaid. Exceptions are:
   - Artificial eyes (coverage per DMERC criteria)
   - Breast prosthesis; prefabricated (coverage per DMERC criteria)

e. Electronically powered or enhanced prosthetic devices are not covered.

f. Corrective shoes or modification to an existing shoe owned by the client are covered only when they are attached to an orthosis or prosthesis or when specially constructed to provide for a totally or partially missing foot.

g. Shoes and accessories such as mismatched shoes, comfort shoes following surgery, shoes to support an overweight individual, or shoes used as a bandage following foot surgery, arch supports, foots pads, metatarsal head appliances or foot supports are **not** covered under the program.

h. Corsets and canvas braces with plastic or metal bones are **not** covered. However, special braces enabling a client to ambulate will be covered when the attending physician documents that the only other method of treatment for this condition would be application of a cast.

i. Some AFOs that are not covered for adults may be covered for children. Use MAVIS or call EDS to check for age limitations.

3.3 Waiver Services

3.3.1 Covered Equipment and Supplies

The following **may** be covered under Waiver services.

- Environmental control devices, air cleaners/purifiers, dehumidifiers, portable room heaters or fans, heating or cooling pads
- Wheelchair lifts for vans
- Emergency response system services
- Generators
- Eating/feeding utensils, such as rocker knives, special plates with rims
- Diverter valves for bathtub
- Home improvements such as:
  - Timers
  - Wheelchair lifts or ramps
  - Electrical wiring
  - Structural modification to the house as listed in Section 3.3.3.1

Note: Waiver services are covered for Enhanced Plan participants only.

3.3.2 Assistive Technology

3.3.2.1 Overview

Assistive Technology (AT) is any item, piece of equipment, or product system beyond the scope of the Medicaid state plan, whether acquired off the shelf or customized, that is used to increase, maintain, or improve the functional capability of the participant. AT items also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment. Items for recreational purposes are not covered.

All items shall meet applicable standards of manufacture, design and installation. The equipment must be the most cost effective to meet the participant's need.

3.3.2.2 Provider Qualifications

Providers must be enrolled as medical equipment vendors with the Medicaid program.

3.3.2.3 Payment

Medicaid reimburses waiver services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid allowance. Environmental modifications, van lifts and personal emergency response systems must be authorized by the RMS prior to payment and must be the most cost-effective way to meet the needs of the participant. In addition, the participant must be

enrolled in the Medicaid Enhanced benefit Plan. The prior authorization number must be included on the claim, or the service will be denied.

Other items must be submitted to the DME Unit for review. If the item cannot be covered under the State Plan DME program, it may be considered under the waiver, if it meets the criteria in **Section 3.3.2.1**. and the client is enrolled in the Medicaid Enhanced benefit Plan. It must be the least costly means of meeting the needs of the participant. The request will be forwarded to the RMS Nurse Reviewer for authorization. The prior authorization number must be included on the claim, or the service will be denied.

3.3.2.4 Procedure Codes

Service	Code	Description
Assistive Technology *A&D Waiver*	E1399 Modifier **U2**	Assistive Technology, by report, amount authorized by Medicaid

3.3.2.5 Diagnosis Code

Enter the ICD-9-CM code for the participant's disability as the primary diagnosis—in field 21 on the CMS-1500 claim form and **V604**, no other household member able to render care, as the secondary diagnosis.

3.3.2.6 Place of Service Codes

Assistive technology can only be provided in the following places of service:

12 – Home

13 – Assisted Living Facility

33 – Custodial Care Facility

Enter this information in field 24B on the CMS-1500 claim form, or in the appropriate field of the electronic claim.

3.3.3 Environmental/Home Modifications

3.3.3.1 Overview

Environmental/home modifications are interior or exterior physical adaptations to the home, required by the client's Plan of Care, necessary to ensure the health, welfare, and safety of the individual. The modifications enable the client to function with greater independence in the home and without which, the client would require institutionalization.

Such adaptations may include:

- Installation of ramps and lifts
- Widening of doorways
- Modification of bathroom and kitchen facilities
- Installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the client

3.3.3.2 Exclusions

Exclusions are those adaptations or improvements to the home that are not of direct medical or remedial benefit to the client, such as:

- Carpeting
- Repairs (roof, plumbing, electrical, etc.)
- Air conditioning

3.3.3.3 Limitations

Permanent modifications are limited to modifications to a home owned by the client or the client's family when the home is the client's principal residence.

Portable or non-stationary modifications may be made when such modifications can follow the participant to the next place of residence or be returned to the Department.

3.3.3.4 Provider Qualifications

Modification services must be completed with a permit or other applicable requirements of the city, county, or state in which the modifications are made. The provider must demonstrate that all modifications, improvements, or repairs are made in accordance with local and state housing, building, plumbing and electrical codes and/or requirements for certification.

3.3.3.5 Payment of Services

Medicaid reimburses waiver services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid allowance. For medical equipment or retail items such as adaptive eating utensils or the chair portion of a lift chair, reimbursement will be 75% of the manufacturer's suggested retail price. The Department will reimburse for the least costly means of meeting the participant's need.

Rates for Waiver services that require a provider to have a license or certification will be negotiated. For home modifications, van lifts, etc., rates will be the cost of the service up to $500 or the lowest of three bids if the cost exceeds $500.

For A&D and TBI Waiver services, all home modifications must be authorized by the RMS prior to payment and must be the most cost-effective way to meet the needs of the participant. In addition, the participant must be enrolled in the Medicaid Enhanced benefit Plan.

For DD Waiver services, all home modifications must be authorized by the ACCESS unit prior to payment and must be the most cost-effective way to meet the needs of the participant. In addition, the participant must be enrolled in the Medicaid Enhanced benefit Plan.

If prior authorization is required, the prior authorization number must be indicated on the claim, or the service will be denied**.**

3.3.3.6 Procedure Codes

Use the following five-digit HCPCS procedure code when billing environmental modification services.

DD Services

Service	Code	Description
Environmental Modifications *DD Waiver*	S5165 Modifier **U8**	Minimum age is 21. Services are authorized by the RMS. 1 unit = 1 service.

TBI Services

Service	Code	Description
Home Modifications *TBI Waiver*	S5165 Modifier **U3**	Home Modifications. Services are authorized by the RMS based on bid.

A&D Waiver

Service	Code	Description
Home Modifications *A&D Waiver*	S5165 Modifier **U2**	Home Modifications. Services are authorized by the RMS based on bid.

3.3.3.7 Diagnosis Code

Enter the ICD-9-CM code for the participant's disability – in the primary diagnosis in field 21 on the CMS-1500 claim form, or in the appropriate field of the electronic claim and **V604**, no other household member able to render care, for the secondary diagnosis.

3.3.3.8 Place of Service

Environmental/home modification services can only be provided in the following place of service:

12 – Home

Enter this information in field 24B on the CMS-1500 claim form, or in the appropriate field of the electronic claim.

3.3.4 Personal Emergency Response System (PERS)

3.3.4.1 Overview

Personal Emergency Response Systems (PERS) are provided to monitor the clients' safety and/or provide access to emergency crisis intervention for emotional, medical, or environmental emergencies through the provision of communication connection systems. PERS are limited to clients who are enrolled in the Medicaid Enhanced benefit Plan and who:

- Rent or own their home
- Are alone for significant parts of the day
- Have no regular caretaker for extended periods of time
- Would otherwise require extensive routine supervision

3.3.4.2 Provider Qualifications

Providers must demonstrate that the PERS devices installed in client's home meet Federal Communications Standards, Underwriter's Laboratory standards, or equivalent standards. Providers must be able to provide, install, and maintain the necessary equipment and operate a response center capable of responding on a 24-hour a day, 7-day per week basis.

3.3.4.3 Payment

Medicaid reimburses Waiver services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance. All PERS services must be authorized prior to payment and must be the most cost-effective way to meet the minimum medical needs of the participant. If prior authorization is required, the prior authorization number must be indicated on the claim, or the service will be denied.

3.3.4.4 Procedure Codes

All claims must use one of the following five-digit HCPCS procedure codes when billing PERS.

DD Services

Service	Code	Description
Initial Installation Fee *DD Waiver*	S5160 Modifier **U8**	Only one installation fee is allowed for each client per residence. This fee includes the installation fee and the first month's service fee. Minimum age is 21. 1 unit = 1 service
Monthly Service Fee *DD Waiver*	S5161 Modifier **U8**	This code can be billed only once per calendar month, and does not include the costs of monthly telephone service. Minimum age is 21. 1 unit = 1 month

TBI Services

Service	Code	Description
Initial Installation Fee *TBI Waiver*	S5160 Modifier **U3**	Initial installation fee, one time only per residence, paid by report based on amount authorized by RMS
Monthly Service Fee *TBI Waiver*	S5161 Modifier **U3**	Monthly service fee 1 unit = 1 month

A&D Services

Service	Code	Description
Initial Installation Fee *A&D Waiver*	S5160 Modifier **U2**	Initial installation fee, one time only per residence, paid by report based on amount authorized by RMS
Monthly Service Fee *A&D Waiver*	S5161 Modifier **U2**	Monthly service fee 1 unit = 1 month

3.3.4.5 Diagnosis Code

Enter the ICD-9-CM code for the client's disability – in field 21 on the CMS-1500 claim form, or in the appropriate field of the electronic claim and **V604**, no other household member able to render care as the secondary diagnosis.

3.3.4.6 Place of Service Code

PERS services can only be billed in the following place of service:

12 – Home

Enter this information in field 24B on the CMS-1500 claim form, or in the appropriate field of the electronic claim.

3.3.5 Specialized Medical Equipment and Supplies

3.3.5.1 Overview

Specialized medical equipment and supplies include devices, controls, or appliances, specified in the Individual Service Plan. The equipment and supplies must enhance the client's daily living and enable the client to control and communicate within his or her environment. This also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid program.

Items covered under the DD waiver/TBI waiver are in addition to any medical equipment and supplies furnished under the Basic Medicaid plan and exclude those items that are of no direct medical, adaptive, or remedial benefit to the client. All items available under the Basic Medicaid plan must be billed by a DME provider. A participant must be enrolled in the Medicaid Enhanced benefit Plan to be eligible for items covered under the DD waiver or TBI waiver programs.

3.3.5.2 Provider Qualifications

Providers must demonstrate that the specialized equipment and supplies purchased under this service meet applicable standards of manufacturer, design and installation, including Underwriter's Laboratory, Federal Drug Administration (FDA), and Federal Communication Commission (FCC) standards.

Specialized equipment must be obtained or provided by authorized dealers of the specific product when applicable (medical supply businesses or organizations that specialize in the design of the equipment).

3.3.5.3 Payment of Services

Rates will be determined by Medicaid on a case-by-case basis. (See costing and prior authorization guidelines for Targeted Service Coordinators for Durable Medical Equipment and Supplies available through the ACCESS units). If prior authorization is required, the prior authorization number must be indicated on the claim, or the service will be denied.

3.3.5.4 Procedure Codes

All claims must use the following five-digit HCPCS procedure code when billing.

DD Services

Service	Code	Description
Specialized Medical Equipment/supplies and Service *DD Waiver*	E1399 Modifier **U8**	1 unit = 1 service

TI Services

Service	Code	Description
Specialized Medical Equipment/supplies and Service *TBI waiver*	E1399 Modifier **U3**	1 unit = 1 service

3.3.5.5 Place of Service

Specialized medical equipment and supply services can only be billed with the following places of service:

12 – Home

99 – Community

Enter this information in field 24B on the CMS-1500 claim form, or in the appropriate field of the electronic claim.

3.4 Claim Form Billing

3.4.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA-compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

All claims must be received within one year of the date of service.

3.4.2 Electronic Claims

For PES software billing questions, consult the Idaho PES Handbook. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

3.4.2.1 Guidelines for Electronic Claims

See **Section 2** for more information on electronic billing.

Detail lines
Idaho Medicaid allows up to **50** detail lines for electronic HIPAA 837 Professional claims.

Referral number
A referral number is required on an electronic HIPAA 837 Professional claim when a client is referred by another provider. Use the referring providers' Medicaid provider number, unless the client is a Healthy Connections client. For Healthy Connections clients, enter the provider's Healthy Connections referral number.

Prior authorization (PA) numbers
Idaho Medicaid allows more than one prior authorization number per electronic HIPAA 837 Professional claim. PAs can be entered at the header or detail of the claim.

Modifiers
Up to **four** modifiers per detail are allowed on electronic HIPAA 837 Professional claim.

Diagnosis codes
Idaho Medicaid allows up to **eight** diagnosis codes on an electronic HIPAA 837 Professional claim.

Oxygen Services
The following oxygen information must be included on every electronic HIPAA 837 Professional claim for oxygen services:

- Oxygen Certification type
- Certification Treatment Period months
- O2 Saturation Quantity and test date
- Arterial Blood Gas Quantity and test date
- Test Condition Code(s)

Electronic crossovers
Idaho Medicaid allows providers to submit electronic crossover claims for Professional services.

3.4.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example: July 4, 2006 is entered as 07/04/2006

3.4.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MM/DD/CCYY) format. Note that in field 24A (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field 24A.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- Be sure to sign the form in the correct field. Claims will be denied that are not signed.
- Do not use staples or paperclips for attachments. Stack them behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).

3.4.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
P.O. Box 23
Boise, ID 83707

3.4.3.3 Completing Specific Fields on the Paper Claim Form

Consult the Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

Field	Field Name	Use	Directions
1a	Patient ID	Required	Enter the seven-digit client ID number exactly as it appears on the plastic client ID card.
2	Patient's Name	Required	Enter the client's name exactly as it appears on the Medicaid plastic ID card. Be sure to enter the last name first, followed by the first name and middle initial.
9a	Other Insured's Policy or Group Number	Required if applicable	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the policy number.
9b	Other Insured's Date of Birth/Sex	Required if applicable	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required if applicable	Required if field 11d is marked YES.
9d	Insurance Plan Name or Program Name	Required if applicable	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Condition Related to Employment?	Required	Indicate yes or no if this condition is related to the client's employment.
10b	Auto Accident?	Required	Indicate yes or no if this condition is related to an auto accident.
10c	Other Accident?	Required	Indicate yes or no if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check yes or no if there is another health benefit plan. If yes, return to and complete items 9a-9d.
14	Date of Current: Illness, Injury or Pregnancy	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required if applicable	Use this field when billing for a consultation or Healthy Connections client. Enter the referring physician's name.
17a	ID Number of Referring Physician	Required if applicable	Use this field when billing for a consultation or Healthy Connection client. Enter the referring physician's Medicaid provider number. For Healthy Connections clients, enter the provider's Healthy Connections referral number.

Field	Field Name	Use	Directions
19	Reserved for Local Use	Not required	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the ICN of previous claims to establish timely filing.
21 (1-4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to 4) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required	If applicable, enter the prior authorization number from Medicaid, DHW, RMS, ACCESS, RMHA, EDS, Quality Improvement Organization (QIO), or MTU.
24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). **Example:** November 24, 2006 becomes 11242006 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24D 1	Procedure Code Number	Required	Enter the appropriate five-character CPT or HCPCS procedure code to identify the service provided.
24D 2	Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as four. Otherwise, leave this section blank.
24E	Diagnosis Code	Required	Use the number of the subfield (1-4) for the diagnosis code entered in field 21.
24F	Charges	Required	Enter your usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H1	EPSDT (Health Check) Screen	Required if applicable	Not required unless applicable. If the services performed constitute an EPSDT program screen, refer to the instructions for EPSDT claims in the provider handbook.
24I	EMG	Desired	If the services performed are related to an emergency, mark this field with an **X**.
24K	Reserved for Local Use	Required if applicable	When a group, agency, or clinic is the billing agency, enter the Idaho Medicaid provider number of the provider rendering the service in Field 24K and the group provider number in field 33.
28	Total Charge	Required	Add the charges for each line then enter the total amount.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance payments including Medicare. Attach documentation from an insurance company showing payment or denial to the claim including explanation of denial reason.
30	Balance Due	Required	Enter the total charges, less amount entered in amount paid field.

Field	Field Name	Use	Directions
31	Signature and Date	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See Section 1.1.4 for more information.
33	Provider Name and Address	Required	Enter your name and address exactly as it appears on your provider enrollment acceptance letter or RA. If you have had a change of address or ownership, please, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
33	GRP — Provider Number	Required	Enter your nine-digit Medicaid provider number.

3.4.3.4 Sample Paper Claim Form

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statement on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500